

MONITORING REPORT ADULT DAY CARE AND ADULT DAY HEALTH
--

DATE OF VISIT: _____

I. PROGRAM: _____ COUNTY: _____

II. TYPE OF VISIT: () Announced () Unannounced TIME OF VISIT: _____

III. ENROLLMENT: # Full-time ____ # Part-Time ____ Month Reviewed _____

ATTENDANCE: # Participants at time of visit ____ # of Staff _____

IV. CONCERNS FROM PREVIOUS VISIT: _____

Have these concerns been resolved? () YES () NO (If no, complete DSS Form 6215)

DO NOT COMPLETE IF THE PROGRAM DOES NOT PROVIDE OR CONTRACT FOR TRANSPORTATION

V. AREA REVIEWED:

Transportation [10A NCAC 06R .0503 and 06S .0404] – <u>Standards</u> , Page 25 and 26
--

Yes No*If applicable, it is recommended you ride with the van as a part of your monitoring visit.*

() ()

Transportation provided in keeping with the needs of participants.

() ()

Each person transported has a seat on the vehicle.

() ()

Participants offered opportunity for rest stop at least every 30 minutes.

() ()

Vehicles used for transportation equipped with seatbelts.

() ()

Participants are instructed to use seatbelts while being transported.

() ()

Participants use public transportation, if available. Relative and other responsible parties are encouraged to provide transportation.

VI. COMMENTS/CONCERNS _____

Attach an additional sheet if needed

VII. PROGRAM DIRECTOR'S COMMENTS _____

VIII. Continued by () DSS-6215 (____ # of forms)

IX. Signatures:

Coordinator_____
Date_____
Program Director_____
Date

Make copies for DSS file; Program Director, and State Adult Day Services Consultant.

DAAS-6214 (9-05)

Check Yes, No, or N/A (not applicable). If no, provide explanation.

*If transportation is provided, N/A is not an option. All Standards must be met.